Bedford Board of Health

2016 - 2017 Insurance Information Form for Vaccination

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: Include the whole member ID number and any letters that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Employed? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

For Everyone, please circle response:

1. Is the person to be vaccinated sick today? **Y N**
2. Does the person to be vaccinated have an allergy to a component of the vaccine? **Y N**
3. Has the person to be vaccinated ever had Guillain-Barré syndrome? **Y N**
4. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past? **Y N**

For children 18 years of age and younger: please check the box next to any statements that are applicable:

Is Vaccine for Children (VFC) Program eligible:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my insurance company to be billed. I acknowledge that I (or my child) will receive the Flu Vaccine and I have received the Vaccine Information Sheet, dated August 7, 2015.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
								IM	R Arm L Arm R Leg L Leg	8/7/15	

Provider Name: **Bedford Board of Health** MDPH Provider PIN#: **10119**

Provider Address: **Town of Bedford- BOH 12 Mudge Way, Bedford, MA, 01730**

Signature of Vaccine Administrator: _____ Date: _____